



# Health Enterprise Zones Update

September 19, 2014

# Presentation Overview



- Year One: Challenges & Successes
- Technical Assistance
- Performance Evaluation and Public Reporting
- Cultural Competency Training
- Use of Incentives

# Year One *Successes* Across the Zones



## Expanding Capacity:

- Expand Provider capacity across all Zones
- 11 new or expanded delivery sites (all Zones are providing additional health services)
- 103 FTEs including practitioners, community health workers, programmatic and support staff have been added to the Zones
- 16-Mile mobile medical route

## ER Utilization:

- 70 year old single female: Diabetic
- 67 year old single male: Compression Socks
- 55 year old single male: Dialysis Treatment

# Year One *Challenges* Across the Zones



- Collecting and reporting data and aggregating data across multiple EMR and paper-based systems
- Zone level readmission data
- Numerous reporting requirements
- Recruitment and retention of primary care, dental, and behavioral health providers
- Development of software systems to track Zone efforts
- Coordination of Case Manager and Community Health Worker efforts to avoid duplication
- Changing patient health care utilization patterns
- Utilizing Community Health Workers
- Utilizing the tax and loan repayment incentives

# Year Two *Technical Assistance* Across the Zones



- Work with Zones to collect and report clinical outcomes data
- External evaluator contracted to provide analysis – Beginning October 2nd
- Create an HEZ Learning Collaborative
- Provide technical assistance to each of the Zones in the areas of:
  - Workforce recruitment and retention
  - Performance of gap analysis in the systems of care
  - Evaluation of long-term financial sustainability: establish and monitor clinical practice break-even volume versus actual volume
  - Development of media and marketing strategies

# **Year Two *Technical Assistance* Across the Zones**



## **Chronic Conditions Targeted by Zones**

All five Zones target a reduction in the prevalence of:

- Diabetes
- Cardiovascular Disease
- Obesity and
- Asthma

Specific strategies include:

- Care coordination for high emergency room utilizers
- Patient wellness plans
- Community health and wellness classes
- Improving health information technology capacity and infrastructure



# Performance Evaluation and Public Reporting

- HEZs are required to develop annual performance goals, such as number of primary care providers hired/recruited or number of residents assisted by community health workers. Progress towards reaching these goals is tracked on a quarterly basis.
- The HEZ Dashboard was developed to assess performance on key milestones and deliverables and overall progress and is currently being revised.
- The Dashboards will continue to facilitate public reporting, accountability, and fiscal stewardship.

# HEZ Dashboard



Zone: Caroline/Dorchester  
Total Population of Zone: 36,123  
Date: January – March 2014 (Q4)

## Health Enterprise Zones Dashboard



Associated Black Charities  
Eastern Shore Area Health Education Center  
Dorchester County Health Department

Maryland State Medical Society  
Chesapeake Voyagers, Inc./DRI Dock  
Affiliated Sante Group

Shore Wellness Partners  
Maryland Healthy Weights  
Caroline County Health Department

Hospital Utilization		Annual Rates		2014			
		CY 2012	CY 2013	Q1	Q2	Q3	Year
Dorchester/Caroline	Hospitalization Rate*	143.0	134.5				
	Readmission Rate	12.1%	12.0%				
Maryland	Hospitalization Rate*	110.1	105.0				
	Readmission Rate	13.3%	13.8%				

\*Rate per 1,000 residents.  
Maryland residents hospitalized out of state are not included in data.

Clinical Measures	Baseline	Year Two			
		Q1	Q2	Q3	Q4
# of sites reporting					
# of primary care providers reporting					
# of patients receiving services across sites					
<b>Asthma</b>					
Use of appropriate medications (NQF 36)					
<b>Behavioral Health</b>					
Screening for clinical depression and follow up plan (NQF 418)					
Antidepressant medication management (NQF 105)					
<b>Diabetes</b>					
Diabetes: HbA1c Control (NQF 575)					
Diabetes: LDL Management (NQF 64)					
Diabetes: BP Management (NQF 61)					
<b>Hypertension</b>					
Hypertension: BP Control (NQF 18)					
<b>Smoking</b>					
Smoking Screening & Counseling (NQF 28)					
<b>Obesity</b>					
BMI Screening & Follow-Up (NQF 421)					

Process Measures	Year One Goals	Year One Cumulative Totals			
		Q1	Q2	Q3	Q4
# of HEZ practitioners added* (FTE)	9	3.6	5.4	5.4	10.4
# of unduplicated patients seen across Zone	687	29	200	440	591
Average response time to calls for the mobile crisis team	<60 mins	NA	45 mins	16 mins	10 mins
# of patient visits across Zone		NA	580	1630	3,267
# of students (unduplicated) served in school based wellness centers		NA	60	150	196
# of individuals (unduplicated) participating in Maryland Healthy Weights		12	23	33	46

Key Milestones	Year One			
	Q1	Q2	Q3	Q4
<b>Goal 1: Increase access to primary care services</b>				
Develop and implement SBWC in Caroline County				
Open Federalsburg adult mental health clinic				
Expand primary care services at Chesapeake Women's Health				
<b>Goal 2: Increase community health resources</b>				
Implement Community Health Outreach Teams				
Implement peer substance abuse recovery program				
Implement Shore Wellness home visiting program				
<b>Goal 3: Promote Cultural Competency</b>				
Provide cultural competency training to collaborative partners				
	Completed	On-Task	Delayed	

Completed Milestones	
✓	Develop and implement SBWC in Dorchester County
✓	Initiate new mobile health crisis team
✓	Initiate Maryland Healthy Weights program

\*Includes direct and indirect licensed health care providers who provide primary care, behavioral health or dental services in the Zone (physicians, NPs, PAs, psychiatrists, psychologists, dentists, RNs, dental hygienists, LCSWs, licensed clinical professional counselors, and licensed substance abuse service providers).



# New Data Measures Template



HEZ State Stat Metrics for Annapolis				
	Oct - Dec 2013	Jan - Mar 2014	April - June 2014	
	Year 1 Quarter 3 (cumulative total)	Year 1 Quarter 4 (cumulative total)	Year 2 Quarter 1 (cumulative total)	
Goal: Increase or Maintain Service Capacity				
Number of Licensed Independent Practitioners Added*	1 FTE	1 FTE		
Number of Other Licensed or Certified Health Care Practitioners Added*	1 FTE	1 FTE		
Number of Qualified Employees Added* (CHWs and Interpreters)	0 FTE	0 FTE		
Number of Other Support Staff Added*	2 FTE	2 FTE		
Total	4 FTE	4 FTE		
*Added = new or retained positions				
	Year 1 Quarter 3 (not cumulative)	Year 1 Quarter 4 (not cumulative)	Year 2 Quarter 1 (not cumulative)	
Goal: Reach Patients with Services				
Number of HEZ (unduplicated) patients seen by clinic/practice				
Morris Blum Clinic, Morris Blum residents	45	36		
Morris Blum Clinic, reside outside Morris Blum	252	218		
Number of 911 calls from Morris Blum residents	48	57		
Number of ED visits among Morris Blum residents	47	49		
Total Number of Patient Visits throughout HEZ	433	482		
Total Number of Unduplicated Patients throughout HEZ	297	254		
Educational/wellness/self-management interventions				
Number of participants in Care Coordination Program	N/A	N/A		
Number of diabetic screening participants	N/A	229		
Number of participants in diabetes self-management program	N/A	17		
Number of participants at community health events	30	107		
GOAL: Assure Clinical Provider Quality	Baseline	Year 1	Year 2	
Selected NQF metrics that reflect guideline adherence				
Asthma: Use of appropriate medications (NQF 36)				
Depression: Screening and Follow up (NQF 418)				
Smoking: Screening and counseling (NQF 28)				
Obesity: BMI screening and follow up (NQF 421)				
	CY 2012		CY 2013	
GOAL: Health Improvement	Annapolis HEZ	Maryland	Annapolis HEZ	Maryland
HSCRC hospital admissions per 1,000 residents	138.5	110.1	121.8	105
HSCRC hospital readmissions rate	13.6%	13.3%	12.3%	13.8%

# Cultural Competency Training



## Anne Arundel:

- 7 Leadership Members, 14 Frontline Staff Members

## Dorchester/Caroline County:

- 5 Leadership Members, 8 Frontline Staff Members

## West Baltimore:

- 14 Leadership Members, 8 Frontline Staff Members

## MedStar Hospital St. Mary's:

- 5 Leadership Members, 18 Frontline Staff Members

## Prince George's County Health Department:

- 6 Leadership Members, 15 Frontline Staff Members

## Global Visions Health Care – Prince George's County- Capitol Heights:

- 1 Leadership Members, 4 Frontline Staff Members

## Gerald Family Health Center – New HEZ Site opening October 2014:

- 5 Leadership Members, 15 Frontline Staff

# HEZ Incentives



- **Health Care Practitioner Personal Income Tax Credit:**
  - As of April 28, 2014, eligible health care providers may apply for a tax credit in an amount equal to 100% of the amount of State income tax.
    - A total of 6 providers have applied to date; 3 have been certified for the credits.
- **Employer Hiring Tax Credit:**
  - Eligible employers participating in the HEZ initiative that hire health care practitioners, community health workers, or interpreters may receive \$5,000 per year over a two-year period per employee. Regulations will be finalized following the end of the comment period (October 6) and a webinar will be hosted for Zones re: use of the hiring tax credit.
- **Loan Repayment Assistance:**
  - Maryland Loan Assistance Repayment Program (MLARP)
  - Janet L. Hoffman Loan Assistance Repayment Program
    - In year one, a total of 6 applicants applied; 3 received assistance. In year two, one applicant has applied to date.

**Questions?**